DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 6/23/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445406	A. BUILDING _____ B. WING _____	06/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE OF RUTHERFORD	901 COUNTY FARM RD MURFREESBORO, TN 37127

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F 000	INITIAL COMMENTS During the annual Recertification survey conducted on June 6-8, 2011, at Community Care of Rutherford County, no deficiencies were cited in relation to complaints # 27749 and #27528 under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	This Plan of Correction (POC) constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by state and federal law.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, laboratory log review, policy review, and interview, the facility failed to obtain a laboratory specimen as ordered by the physician for one resident (#4) of twenty-six residents reviewed. The findings included: Resident #4 was admitted to the facility on March 23, 2011, with diagnoses including Persistent Vomiting, Late Effect Cardiovascular Accident, and Esophageal Reflux. Medical record review of the physician phone order dated April 22, 2011, revealed "...3. T4 TSH (thyroid studies) in 2 weeks..." Medical record review revealed no laboratory data for thyroid studies in May 2011. Review of the May 2011, Laboratory Log revealed no documentation of resident's #4 thyroid studies.	F 281	The Facility will provide or arrange services that meet professional standards of quality related laboratory services. Resident # 4 6/6/11-Medical Doctor (MD) notified of status of May T4 TSH thyroid studies lab. 6/6/11 Lab performed – no change in levels 6/7/11 MD/RP notified of results of May lab with order for:-synthroid to be decreased to 250mcg. Repeat T4 TSH in 2 weeks. 6/6/11 Nurse Managers (NM) conducted 100% audit of lab orders to ensure compliance for all lab orders. In the event a NM is out of facility for an extended period of time, a Minimum Data Set nurse (MDS) will be the proxy. 6/7/11MD notified and all lab studies are updated and logged appropriately. 6/7/11-Diagnostic Testing Services Policy reviewed and revised by nursing management/MD with revision to require a second Licensed Nurse to review all MD orders and sign to validate timely and accurate transcription. 6/20/11All Licensed Nurses (LN) were in-serviced by Director of Nursing (DON) on Diagnostic Testing Services Policy related to process for logging monthly laboratory services. 6/13/11Nurse Managers will audit 100% of telephone orders on a daily basis. Director of Nursing will ensure audits are conducted for on-going compliance. All findings will be forwarded to the QAA Committee (Quality Assessment Assurance Committee) for review and recommendations. Facility Administrator will ensure all findings and recommendations are evaluated during the facility's QAA meeting which will be conducted at least quarterly with attendees to include but not limited to the Medical Director,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Charles R. Hix | Administrator | 6/24/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 Review of the facility policy for Diagnostic Testing Services revealed "...Process...3. Upon receipt of Lab order, the receiving nurse is responsible for placing the order into the lab log for the month ordered and completing the requisition..." Interview on June 6, 2011, at 3:25 p.m., in the conference room, with Licensed Practical Nurse (LPN) #2, confirmed LPN #2 received the April 22, 2011, phone order. Further interview confirmed the order was not on the May 2011 Laboratory Log and the thyroid specimen was not obtained by the facility.	F 281	DON, NHA, Social Worker, Activity Director, Certified Dietary Manager, Maintenance and Housekeeping Director.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility documentation, observation, and interview, the facility failed to ensure a wheel chair was properly secured during van transportation for one resident (#8) of twenty-six residents reviewed; and failed to secure one of one treatment cart. The findings included:	F 323	The facility will ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents Resident # 8 No decline in function related to 6/2/11 incident. Currently in hospital due to a non-related medical diagnosis, elevated temp. 6/3/11 Wheelchair use in bus was assessed by administration and Occupational Therapy to determine best placement for long-based wheelchairs, regular wheelchairs & electric wheelchairs. 6/7/11 Policy for securing wheelchairs was developed to address type of wheelchair, location/placement within the bus to ensure secure placement during transportation. 6/7-17/11 All employees responsible for transport of residents in the bus were in-serviced by staff member responsible for bus transportation with return demonstration offered. Policy is posted on the bus: in the maintenance book and by the seatbelts in the back of the bus. 6/7/11 Housekeeping Director and Bus Driver are responsible to monitor placement of policy to ensure it is visible at all times for transportation. 6/12/11 Housekeeping Director will conduct random observation of the bus at least weekly to ensure residents/wheelchairs are appropriately placed in bus and secured.	

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F 323	Continued From page 2 Resident #8 was admitted to the facility on February 2, 2011, with diagnoses including Acute Transverse Myelitis to Lower Extremities, Hypertension, Obesity, and Cellulites of Leg. Medical record review of the Minimum Data Set dated March 4, 2011, revealed the resident had impairment on both sides of the lower extremities. Review of the facility's fall investigation information dated June 2, 2011, revealed the resident tipped over in the wheelchair while being transported in the facility's van. Continued review revealed the facility failed to lock all wheels on the wheelchair prior to transporting. Interview with the interim Director of Nursing on June 7, 2011, at 10:00 a.m., at the H-wing nurses' station, confirmed the facility failed to lock all wheels on the wheelchair prior to transporting causing the resident to tip over in the van. Continued interview with the interim Director of Nursing revealed the facility sent the resident to the local emergency room, no conclusive fracture noted. Further interview and medical record review revealed the resident had no further incidents. Resident #25 was admitted to the facility on May 12, 2011, with a diagnosis of Dementia. Medical record review of the resident's current care plan up-dated on June 1, 2011, revealed the resident wandered on the unit and into other resident rooms and was resistant to re-direction. Observation on June 7, 2011, from 4:33 p.m. to 4:35 p.m., in the F- hallway revealed the wound treatment cart unlocked and no staff present in	F 323	Resident #25 Resident was within five (5) feet of unlocked treatment cart before the licensed nurse returned to secured/locked the treatment cart. 6/6/11- MSDS sheet was secured for each medication in the cart for staff education and reference. 6/16-6/20/11- DON in-serviced all Licensed Nurses regarding current policy requiring the treatment cart to be locked at all times when the nurse is not in attendance. 6/13/11 -- Sign placed on cart to remind nurses to "LOCK BEFORE LEAVING". 6/13/11 LN will check treatment cart during change of shift to ensure it is secured/locked. 6/13/11 NM will conduct random audits of treatment carts between hours of 7A-11 PM to ensure they are locked in accordance with policy. NM will ensure treatment cart observation audits are conducted for on-going compliance. All findings will be forwarded to the QAA Committee (Quality Assessment Assurance Committee) for review and recommendations. Facility Administrator will ensure all findings and recommendations are evaluated during the facility's QAA meeting which will be conducted at least quarterly with attendees to include but not limited to the Medical Director, DON, NHA, Social Worker, Activity Director, Certified Dietary Manager, Maintenance and Housekeeping Director.	

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F 323	Continued From page 3 the hallway. Continued observation revealed resident #25 was within five feet of the unlocked, unsupervised, wound treatment cart. The resident was not observed to attempt to open the drawers. Continued observation revealed at 4:35 p.m., the wound treatment nurse arrived at the treatment cart. Review of the inventory list of the contents of the treatment cart provided by the facility that had warning labels of "keep out of the reach of children" included: Prep Site (used to help dressings adhere to skin); alcohol based hand sanitizer; zinc oxide (cream used for irritated skin); Bactroban (antibiotic ointment); Premarin cream (hormonal cream); Nystatin powder (antifungal); Nystatin and Triamcinolone (to treat irritated skin); Baza cream (used to treat irritated skin); Equate Athlete's foot; Muscle Rub (for sore muscles); Freezit (for sore muscles); Granulex spray (warning to not spray into eyes or inhale spray); Happy Hiney Ointment; Isopropyl Alcohol; Hydrogen Peroxide; Benzalkonium Chloride Swabsticks (cleanse wounds); povidone iodine Swabsticks (cleanse wounds); and Bacitracin ointment (antibiotic). Interview on June 7, 2011, at 4:35 p.m., with the wound treatment nurse confirmed the wound treatment cart was unlocked, unsupervised, and the contents of the drawers could have been easily accessed.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425	The facility will ensure the pharmacy accurately documents the physician orders on the monthly recapitulation orders each month	

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F 425	Continued From page 4 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure the pharmacy accurately documented the physician orders on the monthly recapitulation orders for two (#5, #7) of twenty-six residents reviewed. The findings included: Resident #5 was admitted to the facility on November 18, 2008, and readmitted on March 11, 2011, with diagnoses including Diabetes Mellitus, and Percutaneous Endoscope Gastrostomy. Medical record review of the March 11, 2011, readmission order revealed "...Glucerna 1.5	F 425	Resident # 5 MD ordered/intended to have Glucerna 1.5 calorie tube feeding formula at 75cc/hour. Resident was receiving Glucerna 1.5 calorie tube feeding formula at 75cc/hr. There was no weight loss. 6/7-8/11- Pharmacy notified by Certified Dietary Manager (CDM) and Nursing Home Administrator (NHA) of transcription error related to feeding formula. Monthly Physician Recapulation order and MAR was corrected to reflect correct order to match the tube feeding formula being delivered via tube. Resident # 7 MD ordered/intended to have Glucerna 1.5 calories at 85cc/hour. Resident was receiving Glucerna 1.5 calorie tube feeding formula at 85cc/hour. 6/7-8/11 – Pharmacy notified by CDM and NHA of transcription error related to feeding formula. Monthly Physician Recapulation order and MAR was corrected to reflect correct order to match the tube feeding formula being delivered via tube. 6/10/11 - Nurse Manager conducted 100% audit of residents receiving nutrition via tube feeding to ensure 100% compliance for MD orders/transcription accuracy/printed Recapulation Physician Order and MAR accuracy. 6/10/11-Policy developed requiring two (2) nursing signatures/review to ensure accuracy in transcription of physician orders and monthly "change over" orders to ensure all MD orders are transcribed correctly from the original order to the Recapulation Physician Order and MAR 6/20/11 DON conducted all Licensed Nurse In-service related to new Policy for Checking Physician Orders to include monthly "change over" orders. By the 15th each month the Medical Records nurses will audit 20% of the active medical records for transcription accuracy. DON will ensure MD order audits are conducted for on-going compliance. All findings will be forwarded to the QAA Committee (Quality Assessment Assurance Committee) for review and recommendations. Facility Administrator will ensure all findings and recommendations are evaluated during the facility's QAA meeting which will be conducted at	

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F 425	Continued From page 5 (calorie) (tube feeding formula for diabetics) at 75 milliliters (ml) per hour for 16 hours..." Medical record review of the April 2011, Recapitulation Order revealed "...Glytrol Enteral...for Glucerna 1.5 cal (calorie)/ml give 75 cc/hr (cubic centimeters per hour) for 16 hour..." Medical record review of the May and June 2011, Recapitulation Orders revealed "...Glytrol...give 75 cc/hr for 16 hr..." Observation on June 7, 2011, at 7:40 a.m. and 1:24 p.m., in the resident's room, revealed a bottle of Glucerna 1.5 calorie with the label identifying the pump rate of 75 cc/hr. Further observation revealed the pump rate was set at 75 cc/hr. Interview with the interim Director of Nursing, in the conference room, on June 7, 2011, at 2:05 p.m., confirmed the facility had administered Glucerna 1.5 since the March 11, 2011, readmission and the pharmacy had failed to correctly identify the tube feeding formula, Glucerna 1.5, on the April, May and June 2011, Recapitulation Orders. Resident #7 was admitted to the facility on September 8, 2010, and readmitted to the facility on May 4, 2011, with diagnoses including Diabetes Mellitus, and Percutaneous Endoscope Gastrostomy. Medical record review of the physician phone order dated May 5, 2011, revealed "...D/C (discontinue) Glucerna (tube feeding formula for diabetics) 1.5 (calories) @ (at) 65 ml/hr (milliliters per hour)...Start Glucerna 1.2 (calories) @ 85	F 425	least quarterly with attendees to include but not limited to the Medical Director, DON, NHA, Social Worker, Activity Director, Certified Dietary Manager, Maintenance and Housekeeping Director.	

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F 425	Continued From page 6 ml/hr x (for) 22 hr..." Medical record review of the June 2011, Recapitulation Order, signed by the physician on June 2, 2011, revealed "...Glucerna 1.2 @ 65 cc/hr (cubic centimeters per hour) x 22 hr..." Observation on June 6, 2011, at 10:31 a.m. and 1:43 p.m., and June 7, 2011, at 7:47 a.m. and 9:58 a.m., in the resident's room, revealed a bottle of Glucerna 1.2 with the label identifying the pump rate at 85 cc/hr. Further observation revealed the pump was set at 85 cc/hr. Interview with Licensed Practical Nurse #1, on June 7, 2011, at 9:58 a.m., in the resident's room, confirmed the tube feeding administered was Glucerna 1.2 at a rate of 85 cc/hr. Further interview confirmed the May 5, 2011, phone order was Glucerna 1.2 at 85 cc/hr. Interview with the interim Director of Nursing, on June 7, 2011, at 2:05 p.m., in the conference room, confirmed the pharmacy failed to correctly identify the tube feeding rate of 85 cc/hr per the May 5, 2011, phone order, on the June 2011, Recapitulation Order.	F 425		